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ABSTRACT

This first-person account of a case study on family therapy discusses two latency-age boys who were referred for treatment. The assessment was that in both cases it was the family itself that was disturbed and needed treatment. The therapist worked with the first boy and his family together. The therapy model used was the "proper" family counseling method. Although changes occurred in the family, therapy was not successful for the child. In the second case, it proved impossible to follow the model of seeing the entire family in therapy. This family, which was handled "improperly"--by the therapist's standards--resulted in apparently successful therapy. This contrasting result led to some revision and re-evaluation of the therapist's original notions about "proper" family therapy. (Author/BMW)

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FAMILY THERAPY: A VERY PROPER FAILURE

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Several years ago, two families were referred to me for treatment at about the same time. In both families, the presenting patient was a latency-age boy with what was seen as an "incipient schizophrenic process," but my own assessment indicated in both that it was the family itself that was disturbed and needed treatment. I was fully convinced that by having the entire family present during therapy sessions, we would have the highest probability of bringing about the needed change in their pathological patterns. I was also convinced that if family members -- usually the fathers -- were resistant to cooperating, in the event that the family remained intact there would be adverse effects. While I was eager to avoid labeling the scapegoated child as "the patient," I was not then sufficiently aware of the adverse effects of deemphasizing the centrality of the presenting patient in the therapy relationship.

Armed with some family systems background and several new family interaction techniques, I went to work on turning around the schizophrenic nature of the family process. The family which is the main focus of this case report was very cooperative. They all came to the sessions, and they went through a course

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of therapy which seemed to me proper and technically sound.

While the "proper model" was applied, and change seemed to be occurring in the family, the therapy was not successful for the child. When I finally realized that our "perfect" sessions were not working, it was still hard to get them to give up their dependence on this therapy which had failed.

In the second case, it proved impossible to follow the model of seeing the entire family together for therapy. Yet that was the model that I thought proper. The family which was handled "improperly" by my intended standards resulted in apparently successful therapy. The occurrence of this contrasting result led to some loosening and revision of my then strong notions on the "proper," family systems approach to therapy.

(All of the names in the following cases are entirely fictitious).

Case 1. Mrs. Moon contacted me as a result of a school referral. David's schoolwork had been characterized to her as erratic. While it was superior on some occasions, at other times it was poor or left incomplete. When approached by teachers or the principal in his private school, he either withdrew, seemed not to hear, or blamed his poor performance on distractions by a school mate who sat at a nearby desk. At other times, he seemed preoccupied and looked out of the window. Mrs. Moon stated that David was bright but "lazy," and that the school had exaggerated the problem. However, she was interested in therapy because David was very hard to live with, he "didn't listen", and she felt troubled about the quality of their family life.

She said, "I thought my home was pretty bad when I was a child, but my kids have it even worse."

Diagnostic evaluation revealed that David was superior in intelligence, and evidenced no learning disabilities, but was rather a disturbed boy. During the interpretive hour, mother spontaneously stated her concern with the functioning of the entire family unit. While most of the attention of this highly verbal woman was directed toward David, who was continually scapegoated in the process, she strongly criticized her husband as well. She expressed great dissatisfaction with her husband's lack of warmth and concern, and felt the entire burden of raising the children was on her. While David was the one with the most obvious problems now, she felt that his example could lead to problems for her younger son, Robert, which was already being manifested in a certain degree of social immaturity in the classroom (he was the "class clown"). Floyd, the husband said little throughout the sessions; indeed, he did little except to loudly correct Edith twice and say "Shut up" twice. He sat throughout most of the session in a darkened corner of the room with a copy of "Ranger Ricks" on his lap. David spent much of the session in a ducking position when criticized, while Robert seemed silent and uncomfortable, with a foolish grin on his face. In response to the suggestion that family sessions be tried, as the problem seemed to involve the whole family, all expressed assent.

It quickly became apparent that having one therapist work with this family alone was insufficient. Interactions were exceedingly complicated at times and too much time was spent

in a dyadic process between the therapist and Edith, the mother. While a therapeutic alliance seemed to be readily formed with Edith, others resisted; indeed, as the appearance of an alliance with Edith increased other family members increased their resistance and withdrew. In the typical scenario at the initiation of sessions, mother would list "family complaints" regarding her own problems and those that she perceived in other members, and would work to engage the therapist in joining her as judge, sympathizer and supporter. Efforts to move away from this pattern, whether through interpretation, role-playing simulations or even paradoxical tasks (Frankl, 1960; Greenberg, 1973) worked only briefly, if at all.

At this point, and with the permission of the family, a male co-therapist was introduced. This person was familiar with the family as he had participated in the original assessment and had studied the videotapes and participated in case conferences in which the case was discussed. While he and I had not previously worked together in family therapy we had a mutually respectful and open relationship, and felt capable of handling disagreements which might occur.

Introduction of the co-therapy arrangement was well-accepted by the family. During the first joint session Floyd, the father, put down his copy of Ranger Ricks and smiled for the first time, and both sons became somewhat verbal. Mother hesitated before jumping into the conversation, and found it harder to maintain her seat as spokeswoman, as the others became more assertive. While her essential therapeutic alliance remained with me, the males in the family were able to develop strong therapeutic

alliances with the male co-therapist and in the process became more vocal and active.

While Floyd's passivity and withdrawal had been strongly criticized by Edith, she found it difficult to relate to him when he was more outgoing. At these times she would provoke him sharply and his mood would go from relative cheerfulness to anger, to withdrawal. In trying to deal with this and other nonproductive family interaction patterns such as the family's continual placement of David on the "hot seat", by the end of six months of therapy we were no longer monitoring the very problem that had brought the family into therapy -- David's severe school problems. Our emphasis on the here-and-now and upon family communication patterns distracted attention from behavior not directly emitted within the sessions or (reportedly) in the family home.

It was only much later that we learned that after an initial period of considerable improvement, in which he became more alert and assertive and both his academic performance and social interactions improved, he began to withdraw more than before. In retrospect, it was clear that early in therapy when his family suppressed their tendency to scapegoat and attack David his school performance greatly improved, both academically and socially. However, as the spotlight of the family shifted, David was essentially excluded from family interactions, and Robert received almost all of the family's attention, both positive and negative. That is, instead of replacing blame of David with loving concern, no replacement was made. He was simply left out.

During a period of time in which Floyd was becoming more vocal and David took Floyd's seat, quietly in a corner next to the pile of Ranger Ricks, he failed all of his mid year examinations.

Nothing of the kind was mentioned during his session that week and it was only months later that we learned that the day after our session he had been found under his desk in school, rocking and crying, while other class members were painting posters.

When mother was called into school during this time period, in contrast to earlier blaming behaviors, in which she allied with the school against her son, she expressed utter disbelief that David could behave immaturely. She insisted to school personnel that the family was in therapy and David was improving. She later told us that she had been very proud of her new way of handling "those school people". This incident was never mentioned during therapy sessions. Instead, the family - primarily Edith, Floyd and Robert, reported great satisfaction with therapy, and expressed the conviction that their quality of life as a family was improving. David was usually silent at those times. They never cancelled sessions or came late, and reported that they really missed their session and the therapists when a holiday or illness of a therapist resulted in postponement or cancellation.

One and a half years after the onset of therapy, the therapists learned that David had been expelled from school. We also learned at that time about his increasingly regressive behavior. We finally realized that our "perfect" sessions were not working with David, who was the primary cause of our initial concern. Indeed his situation within the family and in school had gotten worse. Scapegoating in the family was replaced by virtual exclusion, and school failure by expulsion from school. Even then, it was still hard to get this family to give up their dependence on this therapy which had failed, and to explore other treatment options.

Case 2. In the second case, the identified patient (IP) was a preadolescent boy who was failing in school, having no friends in or out of school. He was often noncommunicative, monosyllabic and sometimes made nonsensical statements. His younger brother resembled him physically, but managed to look handsome and well-coordinated in contrast to the IP who appeared unattractive and awkward. Mother said repeatedly that he looked and was "just like Dad" which invariably brought a "Shut up!" from Dad.

Rita and Al met in college, and had completed about two years of college work when Rita told Al that she was pregnant. They had not seriously considered getting married to each other, before this time. Both dropped out of school and Al worked as a carpet salesman; as he was essentially unsociable this was a difficult and unrewarding job for him, and he was very irritable after work each day. His response was to become very sexually inactive, to demand absolute quiet and obedience from his children and good, uncomplaining service from his wife. As the 2 children grew older, Rita became increasingly interested and successful in activities outside the home, and her confidence and assertiveness increased. This was greatly resented by Al, who felt that he had been deprived of the opportunity to grow because of the family and financial burdens, and that Rita's outside activities were depriving him of a good home life, as well. However, when Rita offered to work so that he could continue his studies toward an engineering degree, he refused, saying that it was "too late." All attempts to get the total family together for sessions failed completely, largely due to Al's resistance. Most frequently, all agreed to come, but Al and his younger son

would go somewhere and "forget" to show up.

Because of the obvious seriousness of the situation for the older son, a consultant was called in to verify the diagnostic impression. Based on an examination of the test materials and interviews, confirmation of the potential for a schizophrenic outcome was given.

The apparent urgency resulted in Al's agreement to come in with Rita, if neither of his "distracting" sons were included. All sessions with Al and Rita were the same, despite all efforts to channel, reflect, interpret and support. Rita came in with a verbal barrage about her own concerns. After 20 minutes Al, who had been completely silent emitted a loud "shut up" and said that all of that was none of anyone's business. He had, after all, agreed to come in just to discuss their sick son. He then would turn to the therapist and say that he had heard enough from his crazy wife and kids at home. He came here to learn from an expert. The therapist should therefore give them a list of ways to handle their child, and he would "make sure" that the family followed their instructions. Whatever was said after this point, Al would invariably exclaim that therapy was "no damn good" and he wouldn't be back. However he invariably reappeared for each of their sessions with Rita, who had reportedly pleaded with him to return. After a total of 10 sessions, Al stopped coming. Rita responded by visibly relaxing, and began what became a very productive course of psychotherapy.

During this time period, Rita returned to college, began working outside of the home, and discovered that she had considerable talent in art. She became increasingly confident and cheerful, and reported very enjoyable times with her sons.

She arranged for play therapy and group therapy for her older son as well. One year after the onset of Rita's individual treatment, Al came into the room where she was laughing with the kids, for the first time in their recollection. He announced that since therapy seemed to be helping them, he had arranged for therapy for himself as well, since he deserved to feel better, too. By all reports, this family is now doing well, without benefit of any family sessions at all. Following several years in therapy for himself and his mother, the original "identified patient" is attending college and functioning well, his brother is doing well in high school, Rita is an art teacher having "the time of her life" and Al is working as a master's level engineer. Above all they report that they are enjoying life.

In retrospect, these early experiences with family therapy strongly reinforced what I had learned once before in my training in individual insight therapy. At least for me, a technique-oriented approach cannot work. Even when careful diagnostic work indicates a choice of a certain type of therapy, or therapist -- there may arise factors in the family system, in the readiness of the client, or the like which preclude the success of that approach. What seems to work best for me is an emphasis on a caring, practical goal-oriented approach in which I am open to the client's own perspective at all times and ready to switch gears at a moment's notice, if necessary. In the list of considerations, type of technique simply must be last, at least for me. While I find it important to be very aware of the surrounding family context in treating clients, and often treat families in conjoint sessions, the choice of approach is governed by the client's needs and not by my preferences. Any orientation which excludes the concerns of every family member appears to lead to therapy that fails.

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